ROSWELL OBSTETRICS AND GYNECOLOGY, LLC

REQUEST/RELEASE OF MEDICAL INFORMATION

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Main Number (770) 751-3600

11975 Morris Rd.	5780 Peachtree Dunwoody Rd., NE	684 Sixes Rd.	1800 Northside Forsyth Dr.
Suite 200	Suite 195	Suite 235	Suite 260
Alpharetta, GA 30005	Atlanta, GA 30342	Holly Springs, GA 30115	Cumming, GA 30041
Fax 770-751-3615	Fax 770-399-2803	Fax 770-924-2896	Fax 678-845-2839

Patient's name:_________________________________Date of Birth:____/____/______

RELEASE FROM:

Name: ________________________________
Address: ______________________________
City, State/Zip: _________________________

Phone: (   )_________________________
Fax: (   )_________________________

RELEASE TO:

Name: ________________________________
Address: ______________________________
City, State/Zip: _________________________

Phone: (   )_________________________
Fax: (   )_________________________

INFORMATION TO BE REQUESTED/RELEASED

Specify date or time period for information requested: _________________

- ________History & Physical/Office Notes
- ________Lab Reports
- ________Operative Reports
- ________Pathology Reports
- ________Prenatal Records, All
- ________Ultrasounds/Mammogram Reports

Roswell OBGYN and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

SPECIFIC AUTHORIZATIONS

Purpose of release/request [check any that apply]:

________Continuity of care or discharge planning (transfer of care)
________Billing and payment of bill
________At request of patient or patient's legal representative
________Other (reason):____________________________
____

I specifically authorize the release of information pertaining to:

__Drug and alcohol abuse, diagnosis, and treatment
__Mental health diagnosis and treatment
__HIV/AIDS testing
__Genetic testing information

NOTICE OF MY RIGHTS

I understand this authorization is voluntary. Treatment, payment enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) obtaining information in connection with eligibility or enrollment in a health plan, for determining an entity's obligation to pay a claim, or creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of information of mental health records.
I may revoke this authorization at any time, provided that I do so in writing and submit it to AWHG c/o Health Information Management, 6285 Barfield Road Atlanta, Georgia 30328. The revocation will take effect when AWHG receives it, except to the extent that I am entitled to receive a copy of the authorization.

Unless otherwise revoked, this authorization expires ______________. If no date is indicated, this authorization will expire in 12 months.

(If the patient is a minor or being legally represented please put parent/guardian information below.)

Print name:____Date: _______________

Signature:____

Please fax records to: "ATTN: MEDICAL RECORDS"

Alpharetta(770) 751-3615 **Interchange(770) 399-2803**

Holly Springs (770) 924-2896 **Cumming (678)845-2839**